



Washington State Department of Health  
**FOODBORNE OUTBREAK REPORTING FORM**  
**PART I - EPIDEMIOLOGIC INVESTIGATION**

DOH USE ONLY

Return completed form to DOH Epidemiology, 1610 NE 150<sup>th</sup> St., Shoreline, WA 98155, Fax (206) 418-5515

I. COMPLAINT/EXPOSURE INFORMATION										
Date of complaint		Complainant name		Address			(H) Phone			
							(W) Phone			
# persons who ate suspect meal: _____		If > 1 person ill do any persons live together? <input type="checkbox"/> Y <input type="checkbox"/> N		Did ill persons have any other meals in common? <input type="checkbox"/> Y <input type="checkbox"/> N			Any ill persons hospitalized? <input type="checkbox"/> Y <input type="checkbox"/> N			
# ill persons who ate suspect meal: _____		Do any ill persons work together? <input type="checkbox"/> Y <input type="checkbox"/> N					Any stool samples submitted? <input type="checkbox"/> Y <input type="checkbox"/> N			
Suspected place of exposure		Address			City			County		
Place Prepared <input type="checkbox"/> Restaurant/deli <input type="checkbox"/> Camp <input type="checkbox"/> Workplace café <input type="checkbox"/> Fair, festival, other mobile <input type="checkbox"/> Day care center <input type="checkbox"/> Caterer <input type="checkbox"/> Nursing home <input type="checkbox"/> Prison, jail <input type="checkbox"/> Other (describe) <input type="checkbox"/> School <input type="checkbox"/> Grocery store <input type="checkbox"/> Private home <input type="checkbox"/> Church, temple, etc. <input type="checkbox"/> Hospital <input type="checkbox"/> Picnic				Place Eaten <input type="checkbox"/> Restaurant/deli <input type="checkbox"/> Camp <input type="checkbox"/> Workplace café <input type="checkbox"/> Fair, festival, other mobile <input type="checkbox"/> Day care center <input type="checkbox"/> Catered event <input type="checkbox"/> Nursing home <input type="checkbox"/> Prison, jail <input type="checkbox"/> Other (describe) <input type="checkbox"/> School <input type="checkbox"/> Grocery store <input type="checkbox"/> Private home <input type="checkbox"/> Church, temple, etc. <input type="checkbox"/> Hospital <input type="checkbox"/> Picnic						
II. EPIDEMIOLOGIC DATA		PERSON NAME/CONTACT INFORMATION								
		Name: Phone: Address:		Name: Phone: Address:		Name: Phone: Address:		Name: Phone: Address:		
		Date interviewed		Date:		Date:		Date:		
		Age and sex		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> M <input type="checkbox"/> F		
		Date and time ate		Date Time am pm		Date Time am pm		Date Time am pm		
ILLNESS INFORMATION	First symptom		<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not ill		<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not ill		<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not ill		<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Not ill	
	Date & time of onset of vomit or diarrhea (whichever occurred first)		Date Time am pm		Date Time am pm		Date Time am pm		Date Time am pm	
	Incubation (indicate minutes or hours)									
	Date & time of last episode of vomit/diarrhea (or still ill)		Date Time am pm		Date Time am pm		Date Time am pm		Date Time am pm	
	Duration (indicate minutes or hours)									
	SYMPTOMS - (+) If person experienced symptom, (-) If person did not experience symptom									
	Nausea									
	Vomiting									
	Abdominal Cramps									
	Diarrhea									
	Avg # of stools in 24/hrs									
	Bloody diarrhea									
	Fever									
	Headache									
	Body ache									
Chills										
Other (list)										
Healthcare provider visit										
Hospitalization										
Stool submitted										
Lab results										
IV. COMMENTS : (For a single case of illness, record all food and drinks consumed in the incubation period of suspected agent/organism. If there is not enough information to categorize the suspect agent, record food and drinks consumed in the 72 hours prior to illness. For 2 or more cases, record common meals in 72 hours before onset of symptoms or in the appropriate time period based on the suspect agent.)										
V. BASED ON EPIDEMIOLOGIC EVIDENCE, THE FOLLOWING IS SUSPECTED: <input type="checkbox"/> Bacterial Toxin <input type="checkbox"/> Bacterial Infection <input type="checkbox"/> Viral <input type="checkbox"/> Chemical <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify)										
VI. FIELD INVESTIGATION CONDUCTED <input type="checkbox"/> Yes (submit Part II, Field Investigation form) <input type="checkbox"/> No (Explain)										

COMPLETED BY (print): \_\_\_\_\_ Agency \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

### 3-DAY FOOD HISTORY (optional, for use by county investigators if desired)

PERSON # \_\_\_\_\_

Day Of Illness Outbreak	One Day Before Illness Outbreak	Two Days Before Illness Outbreak
Date: ____/____/____	Date: ____/____/____	Date: ____/____/____
Brk: _____ _____	Brk: _____ _____	Brk: _____ _____
Lun: _____ _____	Lun: _____ _____	Lun: _____ _____
Din: _____ _____	Din: _____ _____	Din: _____ _____
Oth: _____	Oth: _____	Oth: _____

PERSON # \_\_\_\_\_

Day Of Illness Outbreak	One Day Before Illness Outbreak	Two Days Before Illness Outbreak
Date: ____/____/____	Date: ____/____/____	Date: ____/____/____
Brk: _____ _____	Brk: _____ _____	Brk: _____ _____
Lun: _____ _____	Lun: _____ _____	Lun: _____ _____
Din: _____ _____	Din: _____ _____	Din: _____ _____
Oth: _____	Oth: _____	Oth: _____

PERSON # \_\_\_\_\_

Day Of Illness Outbreak	One Day Before Illness Outbreak	Two Days Before Illness Outbreak
Date: ____/____/____	Date: ____/____/____	Date: ____/____/____
Brk: _____ _____	Brk: _____ _____	Brk: _____ _____
Lun: _____ _____	Lun: _____ _____	Lun: _____ _____
Din: _____ _____	Din: _____ _____	Din: _____ _____
Oth: _____	Oth: _____	Oth: _____

PERSON # \_\_\_\_\_

Day Of Illness Outbreak	One Day Before Illness Outbreak	Two Days Before Illness Outbreak
Date: ____/____/____	Date: ____/____/____	Date: ____/____/____
Brk: _____ _____	Brk: _____ _____	Brk: _____ _____
Lun: _____ _____	Lun: _____ _____	Lun: _____ _____
Din: _____ _____	Din: _____ _____	Din: _____ _____
Oth: _____	Oth: _____	Oth: _____



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**SUPPLEMENTAL FOOD HISTORY SHEET**

PLACE OF EXPOSURE \_\_\_\_\_

COMPLAINT DATE \_\_\_\_\_

	List in the same order as on previous page			
Food item	Person name:	Person name:	Person name:	Person name: